

# **Trauma Care Fund Prehospital Needs Grant Application**

**(2005 – 2007 Biennium)**



**Office of Emergency Medical Services  
and Trauma System**

# Overview and General Application Instructions

## I. Background

The Washington State Department of Health (DOH), Office of Emergency Medical Services and Trauma System (OEMSTS) is accepting grant applications to fund EMS and Trauma prehospital projects that will meet a need or fill a gap in the statewide EMS and Trauma System. The approximate timeline for awarding the grants is April 2006 through June 30, 2007. Three hundred thousand dollars (\$300,000) will be available to fund the grants during the 2005-2007 biennium. Grant funding is made available by the Trauma Care Service Funding Act, which was passed by the Washington State Legislature in 1997.

## II. Purpose

The Trauma Care Fund Prehospital Needs Grants are intended to assist prehospital EMS and Trauma agencies meet a need or fill a gap in the EMS and Trauma System. A “need” is a project/equipment required to meet Revised Code of Washington (RCW), Washington Administrative Code (WAC), or the EMS and Trauma Regional Plan requirements.

## III. Grant Eligibility/Criteria

### A. Who is eligible to apply?

Public and private trauma verified agencies, or licensed agencies seeking to become trauma verified.

### B. Criteria for awarding grants:

- The grant is needed to meet WAC and/or RCW requirements;
- The grant is needed to meet needs identified in the EMS and Trauma Regional Plans (e.g. train personnel to proficiency with a specific skill);
- The grant is needed to implement approved EMS and Trauma Regional Patient Care Procedures, which may include County Operating Procedures.
- The agency must be able to purchase and complete/receive the requested project/equipment between the “Execution Date” of the contract (approximately May/June 2006) and June 30, 2007.
- The Trauma Care Fund Prehospital Needs Grants are “cost reimbursement” grants, therefore the agency must be able to purchase and complete/receive the requested project/equipment before receiving the granted money.

### C. The following are examples of project costs that may be funded (in no particular order). Funding is not limited to this list.

1. Prehospital Trauma Training/Education Projects
2. EMS and Trauma Equipment
3. EMS and Trauma Communications Equipment
4. Prehospital Data Collection Projects (must be NHTS 2.2 compatible)

#### **D. Examples of project costs that cannot be funded:**

1. Anything that does not meet RCW or WAC requirements
2. Projects or equipment of limited benefit
3. Salary upgrades
4. Project or equipment expenditures(s) already budgeted for, or planned for purchase, by the applicant agency (i.e. Needs Grants funds may not displace any item(s) included in current applicant agency budget).
5. Disposable supplies
6. Vehicles
7. Land
8. Office equipment, including computers
9. Electronic hardware (i.e. tablets, computers, palms, printers, fax machines, etc.)
10. Agency information systems (i.e. software)
11. Buildings
12. Injury Prevention Public Education projects

#### **IV. Timelines**

- Workshops to help agencies complete the application, sponsored by the Regional EMS and Trauma Councils, will be available **September 1, 2005 through October 31, 2005.** See attachment A for a listing of scheduled workshops.
- Prehospital agencies must submit grant applications to their Regional EMS and Trauma Council by **November 1, 2005.** See attachment B for addresses and phone numbers.
- The deadline for all grant applications to be submitted to the OEMSTS by the Regional EMS and Trauma Councils is no later than close of business (5:00 pm) **December 15, 2005.**
- The OEMSTS will announce grant awards beginning **April 2006.**
- All awarded grant money must be spent in full by **June 30, 2007.**

#### **V. Application, Submission, Review and Evaluation**

1. Complete the attached application form **in full** (Parts I-IV). Typed applications are preferred, but not required. Additional copies of the application may be obtained by logging on to [www.doh.wa.gov/emstrauma/](http://www.doh.wa.gov/emstrauma/), or by calling or emailing Denece Thomas at 1-800-458-5281, Ext. 7 or (360) 236-2857, or [denece.thomas@doh.wa.gov](mailto:denece.thomas@doh.wa.gov).
2. You may apply for as many grants as you need; however, there can only be one grant request on an application form. **Incomplete applications or applications containing more than one request will be rejected.**

3. Most EMS and Trauma Regions will be holding workshops to provide individual assistance for agencies applying for the Trauma Care Fund Prehospital Needs Grants. You may attend a workshop in any region. See attachment A for a listing of scheduled workshops.
4. You must submit the completed application to your Regional EMS and Trauma Council by **November 1, 2005**. See attachment B for addresses and phone numbers.
5. The Regional EMS and Trauma Councils will submit ALL applications to the OEMSTS by **December 15, 2005**.
6. The applications will be reviewed by the OEMSTS staff, and by a Needs Grant Review Committee.
7. The review process will take into account all information provided in the grant application, the completeness of the application, whether you were a recipient of a previous Trauma Care Fund Prehospital Needs Grant, and if a prior recipient, how well did you comply with contract requirements.
8. Maximum dollar amounts may be established during the Needs Grant Review Committee assessment for projects submitted from various agencies that are similar in nature, but with widespread cost differences (e.g. AEDs, pagers, radios, etc.).
9. The final recommendation for funding will be provided to the EMS and Trauma Care Steering Committee at its **March 2006** meeting. At this same meeting the EMS and Trauma Care Steering Committee will make its funding recommendations to OEMSTS.
10. The OEMSTS will announce grant awards beginning **April 2006**. Following this the OEMSTS will write contracts with grantees, and monitor projects for compliance and completion. Contracts will be on a “cost reimbursement” basis. For example, if a grantee is purchasing a piece of equipment, the item must be purchased and the bill/invoice must be submitted to DOH with an A-19 invoice voucher to receive awarded grant money.
11. All awarded grant money must be spent in full by **June 30, 2007**.

**Questions / need assistance? Call 1-800-458-5281, Ext. 7. Or you may reach us directly at:**

**Copies of the application:** Denece Thomas (360) 236-2857  
[denece.thomas@doh.wa.gov](mailto:denece.thomas@doh.wa.gov)

**General application questions:** Tami Thompson (360) 236-2859  
[tami.thompson@doh.wa.gov](mailto:tami.thompson@doh.wa.gov)

**Local/Regional questions:** *Westside* – Scott Hogan (253) 395-7009  
[scott.hogan@doh.wa.gov](mailto:scott.hogan@doh.wa.gov)

*Eastside* – Pennie Klein (509) 996-7842  
[pennie.klein@doh.wa.gov](mailto:pennie.klein@doh.wa.gov)

# Application and Instructions

Instructions for Completing Part I of the Trauma Care Fund Prehospital Needs Grant Application.

## Part I

### Grants:

- ***Project /Equipment Request:*** Identify in a single sentence or less what it is you are asking for, including the quantity if applicable (i.e. pagers, EMT-B class, etc.).
- ***Agency's EMS/Trauma Budgeted Dollars:*** Provide your agency's EMS/Trauma budgeted dollar amount as described in the narrative in Part II, D of this application.
- ***Number of Grant Applications Submitted:*** Enter the total number of grant applications your agency is submitting to the DOH, OEMSTS for consideration. Please submit one application per project (e.g. If your agency's intent is to apply for grant money for more than one type of equipment, please submit a separate application for each type of equipment.). You may make copies of this application form.
- ***Grant Priority:*** Prioritize all of the grant applications that your agency is submitting, with 1 being the most important to your agency; enter that priority number on the grant application. For example: If your agency is submitting five separate applications, and this request is your third highest priority, enter a 3. No two applications should have the same priority number.
- ***Did you Attend One of the Prehospital Needs Grant Public Workshops?:*** Check the appropriate box that indicates whether or not you attended one of the public workshops that was provided in most of the regions. Note: Your answer to this question will not affect whether or not you receive funding.

### Agency Information:

- ***Agency's Legal Name:*** Enter your agency's legal name as filed with the Washington State Department of Revenue (State Business Records). If you are unsure what it is, visit [www.dor.wa.gov](http://www.dor.wa.gov) and click on the Business Records Database link. You can then search either by agency name or UBI number.
- ***Doing Business As:*** If different than your agency's legal name, enter the name your agency is most commonly known as as.
- ***Agency Code:*** Enter your agency number as assigned by the Department of Health, Office of Emergency Medical Services and Trauma System, Licensing and Certification Section.
- ***Federal ID #:*** Enter your agency's federal identification number.
- ***UBI #:*** Enter your agency's Universal Business Identifier as recorded with the Washington State Department of Revenue. If you are unsure what it is, visit [www.dor.wa.gov](http://www.dor.wa.gov) and click on the Business Records Database link.
- ***Business Phone:*** Enter your agency's business phone number.
- ***Address:*** Enter your agency's address. Please provide both the physical and mailing addresses if different.

- **E-Mail Address:** Enter an e-mail address that may be used for communication about this grant.
- **City/Zip Code:** Enter your agency's city and zip code.
- **Fax:** Enter your agency's fax number.
- **Type of Service:** Check the appropriate box that describes the type of service your agency is licensed as, as identified on your DOH "EMERGENCY MEDICAL SERVICE LICENSE."
- **Level of Service:** Check the appropriate box that describes the level of service your agency is licensed as, as identified on your DOH "EMERGENCY MEDICAL SERVICE LICENSE."
- **Number of EMS Units at Your Agency:** Enter the number of units that your agency has licensed with the Department of Health, Office of Emergency Medical Services and Trauma System, Licensing and Certification Section.
- **Trauma Verification Level:** Check the appropriate box that describes the trauma verification level of service your agency provides, as identified on your DOH "EMERGENCY MEDICAL SERVICE LICENSE."
- **EMS/Trauma Region:** Check the appropriate box that identifies the EMS and Trauma System Region that your agency is located within. The table below identifies which counties are in which region.

<b><u>Central</u></b> King	<b><u>East</u></b> Ferry Stevens Pend Oreille Lincoln Spokane	Adams Whitman Garfield Asotin	<b><u>North</u></b> Whatcom Skagit Snohomish San Juan Island	<b><u>North Central</u></b> Okanogan Chelan Douglas Grant
<b><u>Northwest</u></b> Clallam Jefferson Kitsap Mason	<b><u>South Central</u></b> Kittitas Yakima Benton Franklin Columbia Walla Walla		<b><u>Southwest</u></b> Wahkiakum Cowlitz Clark Skamania Klickitat S. Pacific	<b><u>West</u></b> Grays Harbor Thurston Pierce N. Pacific Lewis

#### **Personnel Information:**

- **Your Personnel/Staff Who Respond To Trauma Calls Are?:** Check the appropriate box.
- **Number of Career:** Enter the number of certified EMS personnel/staff who are career.
- **Number of Volunteer:** Enter the number of certified EMS personnel/staff who are volunteer.
- **Number of Personnel in Each Category:** Enter the total number of certified EMS personnel for each level of certification.
- **Total Number of Calls Per Year:** Enter the total number of calls (fire, EMS, and trauma) your agency responds to each year.
- **What Percent of Your Agency's Calls Are?:** Of the total number of calls that your agency responds to each year, enter the percent of calls for each category.

**Contact Information:**

- **Name:** Enter the name of the person that will be used for all necessary contacts in regards to the application and, if awarded money, questions concerning the contract.
- **Phone:** If different from the agency's phone number, enter a phone number that the contact person may be reached at.
- **Mailing Address:** If different from the agency's mailing address, enter the mailing address to be used for all contact purposes.
- **Cell/Pager:** Enter the cell and/or pager number that the contact person may be reached at.
- **Fax:** If different from the agency's fax number, enter a fax number that the contact person may be reached at.
- **City/Zip Code:** Enter the city and zip code that corresponds to the contact mailing address.
- **E-Mail Address:** If different from the agency's address, enter an e-mail address that the contact person may be reached at.

## PART I

<b>Contact Information</b>		
NAME:	PHONE:	
MAILING ADDRESS:	Cell/PAGER:	FAX:
CITY/ZIP CODE:	E-MAIL ADDRESS:	



## PART II

Please address each numbered item under sections A-E below, by typing or writing your answers on additional sheets of paper, numbering your answers to correspond with each item listed. You are limited to a total of three, single-spaced, preferably typewritten pages. Place your agency name and identify your proposed project/equipment request on each sheet of paper, and attach the sheets to your completed application. An additional three pages of supporting material (e.g. data, maps or brochures, etc.) may be included.

Be as concise, clear, and complete as possible. Emphasis should be placed on information that demonstrates the need and expected impact of your project/equipment request. The narrative provides essential information on which grants are reviewed and funds awarded.

### A. Introduction

1. Identify in clear and concise detail your project/equipment request. State exactly what you are asking for. If applicable, identify the quantity of the project/equipment that you are requesting (e.g. 5 pagers).
2. Complete this statement: **“The goal of this project/equipment request is to...”**.
3. Identify how you will assess or measure the project activity (numbers, classes, events, purchases, etc., that will be completed by a specific date).
4. Provide background information on your agency; describe area served, level of service provided, agency response challenges, etc. (who you are, where you are, whom do you serve, and how do you do it).

### B. Need, Impact and Implementation

1. Describe your need in detail, and reference RCW, WAC, Regional Plan and/or Regional Patient Care Procedures. (Why do you need this project/equipment? What is the evidence of the need? Is there documentation of the need? Is the project/equipment available elsewhere in the county or region?) If your proposed request exceeds the needs/capabilities of your certified personnel or your agencies licensure and/or verification level, please explain why your request exceeds your needs/capabilities.
2. What will be the impact of this program/equipment request on the provision of EMS and Trauma at the local, county, and regional level? Who will potentially benefit and how? Will this project/request be a part of a mutual aid agreement?
3. What will be the impact on your local system if this project/equipment request is not funded?
4. Provide a step-by-step plan, with timeline, for implementation of the project/equipment use. How are you going to complete the project/equipment purchase? When will each step be accomplished (e.g. anticipated month and year)?

### C. Evaluation

1. Please explain how you will measure or evaluate the effectiveness of this project. (e.g. data submittals; class rosters; etc.) **OR**
2. What specific improvement in patient care is expected from the proposed project/equipment requested? (e.g. improved rescue capabilities; cardiac arrest survival rates; etc.).

## **D. Budget/Funding**

1. Complete the Price Estimates Worksheet (Part III). If necessary provide a narrative explanation.
2. What is your agency's EMS/Trauma budgeted dollar amount? Explain the financial need of your agency. You may provide supporting documentation.
3. Are there any type of matching funds available? If so, please explain.
4. What contingency plans do you have if the grant is not funded, or if only partially funded?
5. What, if any, other grants has your agency received in your last fiscal or calendar year, and for what?

## **E. Conclusion**

1. Provide a brief summary and any additional comments you wish to add.

## PART III

### A. Price Estimates

For grant requests other than equipment, please list the estimated expenditures for this grant request in box #1 (only one estimate is required). For equipment requests, please provide three bid amounts in the boxes below, **and attach copies of the price quotes**. Price quotes can be from vendors, websites, etc.

<b>Expenditures or Estimate (Vendor ) #1</b>		
<b><u>Line Item</u></b>	<b><u>Cost of Each Item</u></b>	<b><u>Total Cost</u></b>
	\$	\$
	\$	\$
	\$	\$
<b>Total Cost of Project</b>		\$
<b>Estimate (Vendor) #2</b>		
<b><u>Line Item</u></b>	<b><u>Cost of Each Item</u></b>	<b><u>Total Cost</u></b>
	\$	\$
	\$	\$
	\$	\$
<b>Total Cost of Project</b>		\$
<b>Estimate (Vendor) #3</b>		
<b><u>Line Item</u></b>	<b><u>Cost of Each Item</u></b>	<b><u>Total Cost</u></b>
	\$	\$
	\$	\$
	\$	\$
<b>Total Cost of Project</b>		\$

### B. Preferred Estimate and Reasoning

For equipment requests, please specify your preferred estimate from above and explain why it is preferred.

## Part IV

### Contract Information

**I have reviewed this grant request and attest to the accuracy of the information contained herein. If the grant request is funded, I have the authority on behalf of this agency to sign a contract with the Department of Health, Office of Emergency Medical Services and Trauma System and will assure all terms and conditions of the contract are met.**

AUTHORIZED AGENCY SIGNATURE

DATE

PRINT NAME

PHONE NUMBER